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CLINICAL BREAST EXAMINATION

All women should have a detailed medical history and physical examination performed.

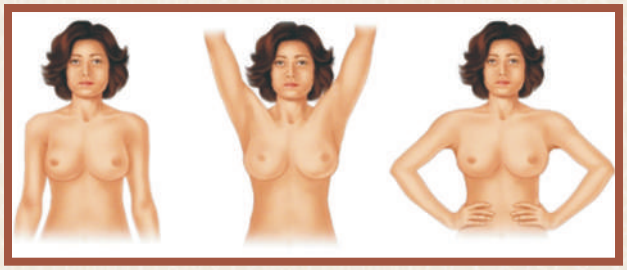
Detailed medical history – previous & current diseases, surgical and other interventions and medications, family history, gynaecological history and history of previous breast complaints or surgeries, especially previous breast biopsies or breast augmentation or reduction.

History of presenting complaint – duration of symptoms (stable, resolving or worsening), symptoms are cyclical or not.

Physical examination – breast, chest region and regional lymph node basins in axilla, infra & supraclavicular fossae should be examined.

Inspection

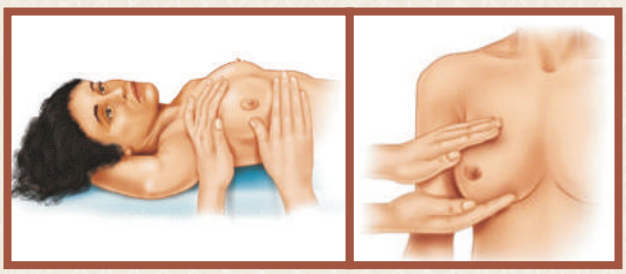
- A chaperone should always be present
- Patient is unclothed till waist and privacy should be maintained
- Inspection starts in upright position with arms by the side, arms raised above the head and with hands on the hips and contracting the pectoral muscle.



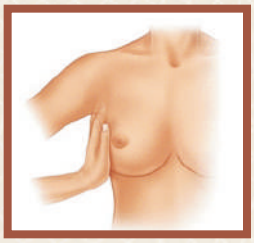
Clinician should observe for breast asymmetry (size, shape or distortion), skin changes (skin retraction, erythema, ulceration, oedema or eczematous changes), changes to the nipple (symmetry, retraction, inversion, nipple discharge or crusting), nipple discharge (unilateral/bilateral, uniduct / multiduct, spontaneous or induced and the colour of the discharge)

Palpation

Inspection is followed by thorough palpation of the breast, axilla, infraclavicular and supraclavicular fossae in upright and supine position.



- Raised local temperature or tenderness if any should be documented.
- If a lump is found – its size, mobility, position and consistency should be assessed. If the lump is fixed , it should be noted whether to the chest wall or skin or to the both.
- If any palpable lymph node (position, number, size, mobile/fixed, solitary / matted) should be documented.



Further investigations are done by radiological examination (mammogram, ultrasonography, MRI) and if required biopsy for HPE.